SASKATCHEWAN BLUE CROSS®

516 2nd Avenue North, PO Box 4030 Saskatoon SK S7K 3T2
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INDIVIDUAL APPLICATION FOR GROUP BENEFITS

- ❑ Health & Dental Benefits
- ❑ Health Spending Account Benefits
- ❑ Wellness Spending Account Benefits

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	INITIAL	BIRTH DATE DD	MM	YY	SEX M/F

MAILING ADDRESS			PHONE #1 ( )
CITY	PROVINCE	POSTAL CODE	PHONE #2 ( )

MARITAL STATUS ❑ Single ❑ Legally Married ❑ Common-Law
If Common-Law, Complete Commencement Date of Co-habitation: DD MM YYYY

DEPENDENT INFORMATION

If more space is required, please attach a separate page listing all information below.

		LAST NAME	FIRST NAME	INITIAL	BIRTH DATE DD	MM	YY	SEX M/F	Dependent Status: Student (College/ University)	Disabled
SPOUSE	01									
CHILD	02									
CHILD	03									
CHILD	04									
CHILD	05									

WAIVER OF BENEFITS

I have been given the opportunity to apply for coverage but do not wish to participate.
I understand that I will not be able to enrol in these plans at a later date without the mutual consent of my employer and Saskatchewan Blue Cross.

I choose to: ❑ Waive ALL benefits ❑ Waive Only: ______________________

Reason: ______________________

COORDINATION OF BENEFITS

Do you or any of your dependents have alternate Health and/or Dental coverage? ❑ Yes ❑ No
If Yes, please complete the following:

	Health	Dental			
EMPLOYEE COVERAGE	❑ Single ❑ Couple ❑ Family	❑ Single ❑ Couple ❑ Family	Insurer / ID No		Policy # / Coverage Effective Date
DEPENDENT COVERAGE	❑ Single ❑ Couple ❑ Family	❑ Single ❑ Couple ❑ Family	Insurer / Cardholder Name	ID No	Policy # / Coverage Effective Date

AUTHORIZATION AND CONSENT

I, the undersigned, declare that the answers to the above questions are complete and accurate and form part of an application for coverage with Saskatchewan Blue Cross and/or Blue Cross Life Insurance Company of Canada® (Blue Cross Life). The discovery of facts known by me or my eligible dependents but not stated in this application could result in the cancellation or modification of coverage or denial of a claim. All information provided herein and collected in the future as part of the application process will be used to determine eligibility for coverage and will be kept confidential and secure. I understand that any coverage which is subject to approval of medical evidence is not effective unless and until approved by Saskatchewan Blue Cross and/or Blue Cross Life. I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by Saskatchewan Blue Cross and/or Blue Cross Life may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to develop and recommend suitable products and services to me and to manage the business of Saskatchewan Blue Cross and/or Blue Cross Life.
Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include other Blue Cross® organizations, licensed physicians and/or any other healthcare professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in my policy or the group policy of which I am an eligible member. I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding the privacy policies of Blue Cross and/or the collection, use or disclosure of my personal information, I can visit sk.bluecross.ca or call 1-800-USEBLUE®.

I certify all of the above information is true and complete. I have read and agree to the Authorization and Consent.

Signature of Applicant ______________ Signature of Witness ______________ Date ______________

TO BE COMPLETED BY EMPLOYER OR ADMINISTRATOR

Name of Employer	Occupation	Permanent Date Employed DD	MM	YY

Payroll No.	Class	HSA Initial Bank Load $ ______	WSA Initial Bank Load $ ______	**Completed for Employer by**
Policy & Section #		Hours Worked per Week ______		Signature ______ Date ______

PLEASE RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS

FOR SASKATCHEWAN BLUE CROSS USE ONLY

ID No.	Policy and Section #	Cross Reference I.D. from	Effective Date DD	MM	YY

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